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Office of Administrative Law Judges
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Issue Date: 07 October 2004

Case No: 2003-BLA-5818

In the Matter of

JESSE J. EVERSOLE

Claimant

v.

PERRY COUNTY COAL CORPORATION
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS

Party-in-Interest

APPEARANCES:

John Hunt Morgan, Esq.
Hyden, Kentucky
For Claimant

Lois A. Kitts, Esq.
BAIRD & BAIRD, PSC
Pikeville, Kentucky
For Employer/Carrier

BEFORE: RUDOLF L. JANSEN
Administrative Law Judge

DECISION AND ORDER — DENYING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended. 30 U.S.C. § 901 *et seq.* Under the Act, benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis also may recover benefits. Pneumoconiosis, commonly known as black lung, is defined in the Act as "a chronic dust disease of the lung and its sequelae, including pulmonary and respiratory impairments, arising out of coal mine employment." 30 U.S.C. § 902(b).

On April 28, 2003, this case was referred to the Office of Administrative Law Judges for a formal hearing. The hearing was held in Hazard, Kentucky on December 3, 2003. The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, arguments of the parties, and applicable regulations, statutes, and case law. They also are based upon my observation of the appearance and demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit received into evidence has been reviewed carefully, particularly those related to the miner's medical condition. The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to "DX," "EX," and "CX" refer to the exhibits of the Director, Employer, and Claimant, respectively. The transcript of the hearing is cited as "Tr." and by page number.

ISSUES

The following issues remain for resolution:

1. Whether the evidence establishes a change in condition or a mistake in a determination of fact pursuant to Section 725.310;

2. Whether Claimant has pneumoconiosis as defined by the Act and regulations;

3. Whether Claimant's pneumoconiosis arose out of coal mine employment;

4. Whether Claimant is totally disabled; and

5. Whether Claimant's disability is due to pneumoconiosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

Claimant, Jesse J. Eversole, was born on February 16, 1928. He married Ruth Browning on June 11, 1948, and they resided together until her death in September of 2001. He had no children who were under eighteen or dependent upon him at the time this claim was filed. (DX 2).

Mr. Eversole experiences shortness of breath upon minimal exertion. (Tr. 14-18). He testified that he can walk no more than 100 feet before becoming short of breath. He uses supplemental oxygen most of the day and throughout the night. In addition, he is prescribed inhalers and utilizes a nebulizer in the treatment of his breathing condition. Mr. Eversole has been hospitalized for breathing problems four times in the twelve months prior to the hearing.

The record contains varying accounts of Mr. Eversole's smoking history. The majority of those accounts report that he began smoking at eighteen years of age and continued to smoke until 1994. (DX 1, 6, 20, 24; EX 2, 8). The majority of the accounts also report a smoking rate of one package of cigarettes per day throughout the smoking history. I am persuaded by the majority of the smoking history accounts and credit Claimant with a smoking history of forty-eight pack years.

Claimant filed his application for black lung benefits on April 19, 2001. A previous claim was denied March 12, 1999 by Decision and Order of an administrative law judge, which was affirmed by the Benefits Review Board on September 19, 2000. As Claimant's current claim was filed less than one year after the prior adjudication, this claim represents a request for modification. The case was transferred to the Office of Administrative Law Judges for a formal hearing. (DX 37).

Coal Mine Employment

The duration of a miner's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. At the hearing, the parties stipulated that Claimant worked 24.5 years in qualifying coal mine work. (Tr. 9).

The record contains Social Security records, which demonstrate the following coal mine employment:

Fourseam Coal Corporation	1948-1953	21 Quarters
Smith Coal Company	1953-1955	9 Quarters
Lynn Mining Company	1955-1960	20 Quarters
Simpson Coal Company	1958-1959	3 Quarters
Franks Coal Company	1961	4 Quarters
Smith Coal Sales Inc.	1962-1965	13 Quarters
Stearns Mining Company	1964-1968	14 Quarters
Perry County Coal Corporation	1970-1975	18 Quarters

(DX 1). This employment totals 25.5 years of qualifying coal mine employment.

In addition, the record reveals that Claimant worked as a mine inspector for the Department of Labor from 1975 to 1985.[1] This work also took place underground. The Benefits Review Board has long held that work as a mine inspector is qualifying coal mine employment. *See Bartley v. Director, OWCP*, 12 BLR 1-89 (1988)(Tait, J., concurring); *Mounts v. Director, OWCP*, 8 BLR 1-425 and 13 BLR 1-44 (1985); *Lynch v. Director, OWCP*, 6 BLR 1-1088 (1984); *Mansell v. Republic Steel Corp.*, 5 BLR 1-842 (1983); *Moore v. Duquesne Light Co.*, 4 BLR 1-40.2 (1981). The record consistently reports ten years of employment as a mine inspector. Therefore, combining all of Claimant's coal mine employment, I conclude that the record supports a finding of 35.5 years of qualifying coal mine employment.[2]

Mr. Eversole last worked for Perry County Coal as a maintenance foreman in 1975. (Tr. 12). In this position, Claimant was often required to lift up to eighty pounds and had to crawl, stoop and crouch in the low coal seams. The majority of Claimant's coal mine employment was underground.

[1] The previous Decision and Order Denying Benefits, issued March 12, 1999, did not include this subsequent employment as the Claimant had not argued that this work was coal mine employment.

[2] The inclusion of Claimant's work as a mine inspector does not alter the determination of the responsible operator in this case. The Federal Government cannot be named a responsible operator; thus, Perry County Coal is the last employer for whom Claimant engaged in coal mine work for more than one year and the responsible operator in this claim. *See Consolidation Coal Co. v. Borda*, 171 F.3d 175 (4th Cir. 1999); *Cornett v. Consolidation Coal Co.*, BRB No. 02-138 (Oct. 15, 2002) (unpublished). Furthermore, Claimant need not exhaust his administrative remedies under the Federal Employees Compensation Act prior to seeking compensation under the Black Lung Benefits Act. *See Borda*, 171 F.3d at 180.

MEDICAL EVIDENCE

X-ray reports

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
EX 8	11/25/03	11/25/03	Broudy/B	1/0
EX 1	10/23/02	10/23/02	Kostelic/unknown	Not read for pneumoconiosis Noted enlarged cardiac silhouette and clear lungs
DX 15	11/19/01	01/03/03	Barrett/B, BCR	1/1
DX 31	11/19/01	06/11/02	Alexander/B, BCR	2/2
DX 24	11/19/01	11/19/01	Dahhan/B	Negative for pneumoconiosis
DX 32	06/06/01	05/28/02	Scott/B, BCR	Negative for pneumoconiosis
DX 12	06/06/01	01/03/02	Barrett/B, BCR	1/1
DX 13	06/06/01	06/06/01	Hussain/none	3/3
DX 14	06/06/01	06/29/01	Sargent/B, BCR	"2" Quality film
DX 11	04/21/01	01/03/03	Barrett/B, BCR	1/1
DX 32	04/21/01	05/28/02	Wheeler/B, BCR	Negative for pneumoconiosis
DX 20	04/21/01	04/21/01	Baker/none	½
DX 23[3]	07/2001	07/2001	Ratcliff/unknown	Not read for pneumoconiosis Noted cardiomegaly
DX 23	06/2001	06/2001	Ratcliff/unknown	Not read for pneumoconiosis Noted COPD with no active disease
DX 23	12/1999	12/1999	Ratcliff/unknown	Not read for pneumoconiosis Noted cardiomegaly
DX 23	06/1999	06/1999	Ratcliff/unknown	Not read for pneumoconiosis Noted COPD and cardiomegaly

[3] The x-ray interpretations read by Dr. Elmer B. Ratcliff and Dr. J. F. Gilbert dating from August of 1988 to July of 2001 were performed during Claimant's various hospitalizations at the Appalachian Regional Hospital in Hazard, Kentucky throughout that time period. The exact dates that the x-rays were taken are not mentioned in the hospital records; therefore, I list only the month and year for these x-ray interpretations.

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX 23	03/1999	03/1999	Ratcliff/unknown	Not read for pneumoconiosis Noted COPD
DX 23	02/1999	02/1999	Ratcliff/unknown	Not read for pneumoconiosis Noted "mild failure"
DX 23	01/1999	01/1999	Ratcliff/unknown	Not read for pneumoconiosis Noted cardiomegaly and COPD
DX 23	09/1998	09/1998	Gilbert/unknown	Not read for pneumoconiosis Noted cardiomegaly and no active disease
DX 23	10/1998	10/1998	Ratcliff/unknown	Not read for pneumoconiosis Noted COPD
DX 23	08/1998	08/1998	Ratcliff/unknown	Not read for pneumoconiosis Noted no active disease
DX 23	06/1997	06/1997	Ratcliff/unknown	Not read for pneumoconiosis Noted cardiomegaly
DX 1	09/02/97	09/02/97	Dahhan/B	Negative for pneumoconiosis
DX 1	03/18/97	04/15/97	Sargent/B, BCR	Negative for pneumoconiosis
DX 1	03/18/97	03/18/97	Wicker/unknown	Negative for pneumoconiosis
DX 1	11/14/94	11/14/94	Patel/unknown	Not read for pneumoconiosis Noted congestion
DX 1	11/12/94	11/12/94	Patel/unknown	Not read for pneumoconiosis Noted no active disease
DX 1	09/30/94	09/30/94	Pampati/unknown	Not read for pneumoconiosis Noted congestive changes
DX 1	09/28/94	09/28/94	Pampati/unknown	Not read for pneumoconiosis Noted no acute infiltrate
DX 1	09/27/94	09/27/94	Pampati/unknown	Not read for pneumoconiosis Noted cardiomegaly

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX 1	09/11/86	12/09/86	Wiot/B, BCR	1/0
DX 1	09/11/86	11/20/86	Felson/B, BCR	1/0
DX 1	09/11/86	10/10/86	Quillen/B, BCR	Negative for pneumoconiosis
DX 1	09/11/86	09/11/86	Broudy/B	0/1
DX 1	04/15/86	08/20/86	Cole/B, BCR	1/1
DX 1	04/15/86	07/29/86	Elmer/B, BCR	Completely negative
DX 1	08/16/85	03/01/86	Elmer/B, BCR	Completely negative
DX 1	08/16/85	02/06/86	Sargent/B, BCR	1/1
DX 1	08/16/85	08/16/85	Nash/unknown	Pneumoconiosis, Stage 2
DX 1	08/16/85	08/16/85	Ramakrishman/unknown	½
DX 1	11/08/84	01/21/85	Sargent/B, BCR	1/0
DX 1	11/08/84	12/07/84	Elmer/B, BCR	Completely negative
DX 1	11/08/84	11/08/84	Williams/B	1/0
DX 1	09/13/84	09/13/84	Speiden/unknown	Abnormalities most likely due to patient's known pneumonconiosis
DX 1	04/05/79	06/04/79	Saba/unknown	Negative for pneumoconiosis
DX 1	04/05/79	04/05/79	Williams/B	0/1
DX 1	09/14/73	09/14/73	Jones/unknown	2/2
DX 1	06/26/73	06/26/73	Blickenstaff/unknown	Pneumoconiosis
DX 1	08/25/70	06/13/73	Stitik/B, BCR	Negative for pneumoconiosis
DX 1	08/25/70	05/02/73	Halpern/B, BCR	Negative for pneumoconiosis
DX 1	08/25/70	11/14/72	Gayler/B, BCR	Negative for pneumoconiosis
DX 1	08/25/70	09/01/70	Rosenbaum/B, BCR	Negative for pneumoconiosis
DX 1	08/25/70	08/25/70	Anderson/unknown	2/2
DX 1	03/05/67	03/06/67	Power/unknown	Clear lung fields

"B" denotes a "B" reader and "BCR" denotes a board-certified radiologist. A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services (HHS). A board-certified radiologist is a physician who is certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association. *See* 20 C.F.R. § 718.202(a)(ii)(C).

Pulmonary Function Studies[4]

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV1/ FVC	Tracings	Comments
EX 8	Broudy	75/71[5]	1.99	3.36	34	59	YES	Good cooperation except for MVV portion of study
11/25/03			*1.91	*3.29	*39	*58		
DX 24	Dahhan	73/70	2.33	3.70	93	63	YES	Good cooperation
11/19/01								
DX 9	Hussain	73/71	2.01	3.83	61	52	YES	Good cooperation
08/03/01								
DX 7	Hussain	73/71	1.91	4.04	43	47	YES	Fair cooperation
06/06/01								
DX 8	Burki							06/06/01 Study invalid due to suboptimal effort
06/23/01								

[4] As there is a discrepancy in the measured heights among the pulmonary function studies, I must make a finding resolving that discrepancy. *Protopappas v. Director, OWCP*, 6 BLR 1-221 (1983). The majority of the heights are recorded at 71 inches. Therefore, I am persuaded by the majority of the accounts and find Claimant's height to be 71 inches.

[5] 20 C.F.R. § 718 App. B establishes the standards for administration and interpretation of pulmonary function tests. The tables only provide standards for persons 71 years of age or younger. In order to determine the standards by which Claimant should be adjudicated, I calculated the ratio by which the values decreased over 13-year time periods in order to extrapolate values for the age of 73 and 75. I find that the qualifying values for a 73 year old male at a height of 71 inches are: FEV_1 = 1.93, FVC = 2.47, and MVV = 77. For a 75 year old male at a height of 71 inches, I find the qualifying values as follows: FEV_1=1.90, FVC = 2.43, and MVV = 76.

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV1/ FVC	Tracings	Comments
DX 20 04/21/01	Baker	73/71	3.35	4.26	127	78	YES	
DX 1 09/02/97	Dahhan	69/71	1.99 *2.42	3.68 *4.50	79 *96	54 *54	YES	Fair cooperation
DX 1 03/18/97	Wicker	69/71	2.02	3.68	90.5	55	YES	Good cooperation
DX 1 09/11/86	Broudy	58/71	3.42	5.50	134	62	NO	Good effort
DX 1 08/16/85	Nash	57/73	.97 *1.81	1.36 *3.16	44 *62	71 57	YES	
DX 1 11/08/84	Williams	56/71	2.82	4.09	77	69	YES	
DX 1 04/05/79	Williams	51/71	3.74		80		YES	
DX 1 09/14/73	Jones	45/71	3.40	4.30	140	79	NO	
DX 1 01/23/71	Unknown	42/72	3.77	5.77	138	65	YES	

*post-bronchodilator values

Arterial Blood Gas Studies

Exhibit	Date	pCO2	pO2	Resting/ Exercise
EX 8	11/25/03	33.9	56	Resting
DX 24	11/19/01	40	91	Resting
DX 10	06/06/01	33.7	60	Resting
DX 20	04/21/01	33	74	Resting
DX 1	09/02/97	38	63	Resting

Exhibit	Date	pCO2	pO2	Resting/ Exercise
DX 1	03/18/97	43	69	Resting
DX 1	09/11/86	37	85	Resting
DX 1	08/16/86	38	62	Resting
DX 1	11/08/84	37	85	Resting
DX 1	11/08/84	27	102	Exercise
DX 1	04/05/79	39	85	Resting
DX 1	04/05/79	32	77	Exercise

Narrative Medical Evidence

Bruce C. Broudy, M.D., examined Claimant on November 25, 2003 and issued an examination report on that date. (EX 8). He provided a chest x-ray, a pulmonary function study and an arterial blood gas study. He considered a thirty-two year employment history and an accurate smoking history. Dr. Broudy diagnosed coronary artery disease, moderately severe chronic obstructive pulmonary disease (COPD), and coal workers' pneumoconiosis. In addition to the examination, Dr. Broudy considered the medical evidence of record. He opined that Claimant is totally disabled due to his cardiac condition and COPD. He determined that pneumoconiosis has no impact on Claimant's respiratory impairment. Dr. Broudy is board-certified in Internal Medicine and Pulmonary Medicine.

Gregory J. Fino, M.D., issued a consultative medical report on October 27, 2003 after reviewing the medical evidence of record. (EX 4). He considered a twenty-five year work history and the accounts of a smoking history reported in the record. Dr. Fino opined that the changes shown in Claimant's respiratory function over time are "consistent with ongoing smoking." He found insufficient evidence in the record to diagnose pneumoconiosis. He determined that Claimant does not have a respiratory impairment, but that Claimant is totally disabled as a result of his cardiac condition. Dr. Fino is board-certified in Internal Medicine and Pulmonary Disease.

Lawrence H. Repsher, M.D., issued a consultative medical report on October 8, 2003 after reviewing the medical evidence of record. (EX 2). Dr. Repsher considered a thirty-five to

thirty-seven year work history and an accurate smoking history. Dr. Repsher opined that the medical evidence may support a diagnosis of simple coal workers' pneumoconiosis and mild COPD. He explained that the variability in the pulmonary function study results show an obstructive defect due, most likely, to smoking. In addition, Dr. Repsher determined that Claimant's hypoxemia, as indicated by the arterial blood gas studies, is explained by Claimant's cardiac condition. Dr. Repsher opined that the pulmonary function studies demonstrate a mild respiratory impairment and indicate that Claimant has the respiratory capacity for coal mine employment. Dr. Repsher is board-certified in Internal Medicine and Pulmonary Disease.

Abdul K. Dahhan, M.D., examined Claimant on November 19, 2001 and issued an examination report on November 26, 2001. (DX 24). He provided a full pulmonary workup, including a chest x-ray, a pulmonary function study, an arterial blood gas study and an EKG. He considered a thirty-seven year work history and an accurate smoking history and he also reviewed the medical evidence of record. Dr. Dahhan opined that his examination and the medical evidence were insufficient to support a diagnosis of pneumoconiosis. He based this determination on normal examination findings, normal results of pulmonary function testing, variable arterial blood gas studies, and a lack of radiological evidence. He explained that the variable hypoxemia, as demonstrated by the arterial blood gas studies, is due to Claimant's coronary artery disease and congestive heart failure. Dr. Dahhan is board-certified in Internal Medicine and Pulmonary Medicine.

Dr. Dahhan issued a supplemental report on March 6, 2002 after reviewing the medical reports of Drs. Glen R. Baker and Imtiaz Hussain. (DX 28). He expressed his disagreement with the diagnosis of pneumoconiosis by those physicians. He noted that Claimant had no recent coal dust exposure, was being treated with bronchodilators and the airway obstruction varied in severity. He opined that these factors did not indicate the presence of pneumoconiosis.

Imtiaz Hussain, M.D., examined Claimant on June 6, 2001 and issued an examination report on that date. (DX 6). He provided a full pulmonary workup, including a chest x-ray, a pulmonary function study, an arterial blood gas study and an EKG. He considered a forty pack year smoking history. Dr. Hussain's report does not address Claimant's employment history. He diagnosed pneumoconiosis based on a positive chest x-ray and the results of the pulmonary function study. He also diagnosed

Claimant with coronary artery disease based on the results of the EKG. Regarding total disability, Dr. Hussain determined that Claimant suffers a severe respiratory impairment, 80% of which is due to pneumoconiosis, preventing Claimant from engaging in coal mine employment. Dr. Hussain is board-certified in Internal Medicine and Pulmonary Medicine.

Glen R. Baker, M.D., examined Claimant on April 21, 2001 and issued an examination report on that date. (DX 20). He provided a chest x-ray, a pulmonary function study and an arterial blood gas study. He considered a thirty-five year work history and a thirty-five pack year smoking history. Dr. Baker diagnosed Claimant with coal workers' pneumoconiosis, mild hypoxemia, chronic obstructive airway disease and chronic bronchitis. He based the diagnosis of pneumoconiosis on a positive chest x-ray and Claimant's history of coal dust exposure. The diagnosis of chronic obstructive airway disease was based on the results of the pulmonary function study and the diagnosis of chronic bronchitis was based on Claimant's history. Using the American Medical Association's Guides to the Evaluation of Permanent Impairment as directed by the Kentucky standard form, Dr. Baker assessed Claimant's impairment as 10-25% impairment of the whole person and recommended that he avoid further dust exposure. Dr. Baker is board-certified in Internal Medicine and Pulmonary Disease.

Mitchell Wicker, Jr., M.D., examined Claimant on March 18, 1997. (DX 1). He provided a chest x-ray, a pulmonary function study, an arterial blood gas study and an EKG. He considered an accurate smoking history, but the report does not contain information regarding Claimant's coal mine employment. Dr. Wicker found the evidence insufficient to support a diagnosis of pneumoconiosis. He further opined that Claimant retains the respiratory capacity for coal mine employment. Dr. Wicker's qualifications are not of record.

Dr. Dahhan examined Claimant on September 2, 1997 and issued an examination report on September 3, 1997. (DX 1). He provided a full pulmonary workup, including a chest x-ray, a pulmonary function study, an arterial blood gas study and an EKG. He considered accurate work and smoking histories. Dr. Dahhan diagnosed COPD based on the results of the pulmonary function study and examination findings. Although the pulmonary function study was invalid due to suboptimal effort, Dr. Dahhan determined that the results showed an obstructive ventilatory defect. Dr. Dahhan opined that Claimant does not have the respiratory capacity to engage in coal mine work due to his

obstructive defect. He determined that the obstructive defect was not caused by coal dust exposure as Claimant had not been exposed to coal dust since 1985, pulmonary function studies demonstrated a reversible component to the defect, and there is no evidence of complicated pneumoconiosis. Dr. Dahhan stated that Claimant's COPD resulted from cigarette smoking.

Dr. Broudy examined Claimant on September 12, 1986 and issued an examination report on that date. (DX 1). Dr. Broudy provided a chest x-ray, a pulmonary function study and an arterial blood gas study. He considered an accurate work history and a smoking history of twenty-five pack years. Dr. Broudy diagnosed Claimant with degenerative joint disease and smoking-induced chronic bronchitis. Finding normal pulmonary function and a lack of radiological evidence, he opined that Claimant does not suffer from pneumoconiosis and has the respiratory capacity to perform coal mine work.

Cordell H. Williams, M.D., examined Claimant on April 15, 1986 and issued an examination report on that date. (DX 1). He provided a chest x-ray. Considering a twenty-three year work history and an accurate smoking history, he diagnosed Claimant with COPD, together with pneumoconiosis. Dr. Williams also examined Claimant on November 8, 1984. (DX 1). He diagnosed Claimant with COPD and pneumoconiosis based on examination findings and a positive chest x-ray. Dr. Williams first examined Claimant on April 5, 1979. (DX 1). At that time, he diagnosed Claimant with mild COPD "with irregular fibrosis two lower zones compatible with 0/1 S otherwise normal." Dr. Williams' qualifications are not of record.

Arthur J. Nash, M.D., examined Claimant on August 16, 1985 and issued an examination report on that date. (DX 1). He provided a chest x-ray, a pulmonary function study and an arterial blood gas study. He considered an accurate work history, but did not discuss Claimant's smoking history. Dr. Williams reported normal pulmonary function study results and that the arterial blood gas study demonstrated moderate hypoxemia. He diagnosed Claimant with moderate deafness, hypertensive cardiac disease, COPD and pneumoconiosis. He opined that Claimant has suffered a 40% reduction in lung function and is totally disabled as a result for coal mine employment or "any heavy activity." Dr. Nash's qualifications are not of record.

Eli C. Boggs, M.D., examined Claimant on September 28, 1985 and issued an examination report on that date. (DX 1). He

diagnosed Claimant with COPD and Stage 2 pneumoconiosis. Dr. Boggs did not discuss the reasoning behind this diagnosis. Dr. Boggs' qualifications are not of record.

Boyce E. Jones, M.D., examined Claimant on September 14, 1973 and issued an examination report on that date. (DX 1). He provided a chest x-ray and a pulmonary function study. He considered a twenty-five year employment history, but his report contains no information regarding Claimant's smoking history. He diagnosed Claimant with pneumoconiosis based on a positive chest x-ray and advised Claimant against further coal dust exposure. Dr. Jones' qualifications are not of record.

Deposition Testimony

Dr. Fino was deposed on December 1, 2003. (EX 7). He affirmed his earlier written report. Dr. Fino explained that the variability in Claimant's airway obstruction, as shown by pulmonary function studies, "points to a smoking-related condition." In addition, he discussed the variability in Claimant's hypoxemia, as shown by the arterial blood gas studies, and stated that this variability was likely due to smoking or Claimant's heart condition. Dr. Fino opined that Claimant is totally disabled due to his cardiac condition.

Dr. Repsher was deposed on November 25, 2003. (EX 6). He affirmed his earlier written report finding that it is "possible" that Claimant has coal workers' pneumoconiosis. He opined that Claimant has a mild respiratory impairment and that it is caused "mostly" by smoking. He determined that Claimant's cardiac condition is totally disabling.

Dr. Broudy was deposed on September 26, 1988. (DX 1). Dr. Broudy affirmed his written report of September 12, 1986.

Treatment Records

The record contains treatment records from Dr. Elmer B. Ratcliff. (DX 1, 23). These records reflect Claimant's treatment from January 17, 1990 until October 24, 2001. Claimant visited Dr. Ratcliff approximately once a month during this time period. The records are largely illegible; however, they indicate that Claimant was being treated for cardiac and respiratory conditions. Dr. Ratcliff's qualifications are not of record.

The record also contains treatment records from Dr. Vidya Yalamachi. (DX 25). Dr. Yalamachi treated Claimant for his cardiac condition. These records report visits to Dr. Yalamachi on December 7, 1998; April 6, 2000; April 27, 2000 and May 31, 2000. Dr. Yalamachi noted the presence of angina and ischemic cardiomyopathy. Dr. Yalamachi's credentials are not of record.

Treatment records from the Kentucky Orthopaedic and Hand Surgeons of Lexington, Kentucky reveal that Claimant underwent surgery on his hands to correct a Dupuytren's contracture in March of 1997. (DX 1).

Treatment records from Dr. Eli C. Boggs reflect treatment for COPD and pneumoconiosis from January 14, 1984 to November 16, 1984. Dr. Boggs recorded on November 16, 1984 that Claimant was ready to return to work.

Drs. Marion G. Brown, Carl M. Friesen, Curwood R. Hunter, and Russell L. Travis issued reports in 1968 discussing treatment given to Claimant after a back injury in 1967.

Hospital Records

The record contains hospital records regarding treatment at the Appalachian Regional Hospital in Hazard, Kentucky from June of 1997 to July of 2001. (DX 23).

Claimant was admitted to the hospital on July 27, 2001 and discharged on July 31, 2001. Chest examination findings of "sticky rales" were noted and a chest x-ray was performed showing cardiomegaly. The discharge diagnoses included early congestive heart failure, arteriosclerotic heart disease, moderately severe COPD, osteoarthritis and gastroesophageal reflux disease (GERD).

From March 26, 2001 until March 30, 2001, Claimant was hospitalized to address pulmonary congestion. Dr. Ratcliff noted the presence of rales in the chest upon examination. A chest x-ray demonstrated COPD "with no active disease." The discharge diagnoses included early congestive heart failure, unstable angina, arteriosclerotic heart disease, COPD, GERD, and essential hypertension.

Claimant was admitted to the hospital on June 14, 2001 and discharged on June 15, 2001 in order to treat Claimant's nausea. Dr. Ratcliff noted that Claimant's lungs were clear upon examination.

Due to a smothering feeling and chest tightness Claimant was admitted to the hospital on June 21, 2000 and discharged on June 24, 2000. Dr. Ratcliff noted the presence of rales and diminished breath sounds upon examination of the chest. The discharge diagnoses included unstable angina, severe arteriosclerotic heart disease, previous episodes of congestive heart failure, and COPD with pulmonary fibrosis. Dr. Ratcliff noted that Claimant should restrict overall activity.

On April 21, 2000, Claimant was admitted to the hospital for smothering and dizziness. Dr. Ratcliff examined the chest and noted the presence of "sticky rales" and diminished breath sounds. The discharge diagnoses included probable early recurrent congestive heart failure, arteriosclerotic heart disease, COPD and chronic feeling of faintness.

Claimant was admitted to the hospital on February 9, 2000 upon complaints of chest pain. Dr. Ratcliff noted "sticky rales" and diminished breath sounds in the chest examination. A chest x-ray demonstrated cardiomegaly. Claimant was discharged on February 14, 2000 with the diagnoses of unstable angina, coronary artery disease, essential hypertension and COPD.

A feeling of smothering required hospital admission from December 3, 1999 until December 6, 1999. Dr. Ratcliff performed a chest examination and noted "crepitant rales" and diminished breath sounds. A chest x-ray showed COPD and cardiomegaly. The discharge diagnoses included early congestive heart failure, ateriosclerotic heart disease, COPD, GERD and essential hypertension.

Shortness of breath required hospital admission from June 15, 1999 until June 21, 1999. Dr. Ratcliff noted diminished breath sounds and rales upon chest examination. A chest x-ray showed cardiomegaly and a nodule in the lungs. The discharge diagnoses included early congestive heart failure, arteriosclerotic heart disease, severe COPD and osteoarthritis.

Claimant was admitted to the hospital on March 20, 1999 and discharged on March 28, 1999. Claimant had experienced a fever. Dr. Ratcliff examined Claimant's chest and noted diminished breath sounds and "sticky rales." A chest x-ray demonstrated COPD. Dr. Ratcliff diagnosed pneumonia, COPD, arteriosclerotic heart disease, essential hypertension and GERD.

Claimant was admitted to the hospital on February 22, 1999 upon complaints of shortness of breath. Dr. Ratcliff noted the presence of rales in a chest examination. A chest x-ray showed "mild failure." Dr. Ratcliff discharged Claimant on February 26, 1999, diagnosing recurrent congestive heart failure, arteriosclerotic heart disease, COPD and GERD.

Chest pressure required hospital admission from January 4, 1999 until January 6, 1999. Dr. Ratcliff examined Claimant's chest and noted rales and diminished breath sounds. A chest x-ray revealed mild cardiomegaly, COPD and "no active disease." The discharge diagnoses included chest pain, osteoarthritis, arteriosclerotic heart disease, GERD and COPD.

On October 25, 1998, Claimant was admitted to the hospital upon complaints of chest pain. Dr. Ratcliff examined the chest and noted diminished breath sounds and rales. A chest x-ray revealed COPD. A CT Scan was performed, in which infiltrate in the right lower lobe of the lung was discovered. Dr. Ratcliff discharged Claimant on November 4, 1998, diagnosing lower lobe pneumonia, COPD, coronary artery disease, arteriosclerotic heart disease and GERD.

Claimant was admitted to the hospital on September 14, 1998 and discharged on September 18, 1998. Dr. Gilbert examined Claimant's chest and noted diminished breath sounds and rales. A chest x-ray demonstrated cardiomegaly and "no active disease." The discharge diagnoses included angina, arteriosclerotic heart disease, COPD, GERD and depression.

On August 28, 1998, Claimant was admitted to the hospital upon complaints of chest pain. Dr. Ratcliff examined Claimant's chest and noted diminished breath sounds and rales. A chest x-ray revealed "no active disease." Claimant was discharged from the hospital on September 1, 1998. The discharge diagnoses included arteriosclerotic heart disease, COPD and GERD.

Claimant was admitted to the hospital on June 6, 1997 and discharged on June 11, 1997. Dr. Ratcliff examined Claimant's chest and reported diminished breath sounds and rales. A chest x-ray revealed cardiomegaly. Dr. Ratcliff listed the discharge diagnoses as arteriosclerotic heart disease, chronic lung disease and GERD.

The record also contains Appalachian Regional Hospital records from January 18, 1990 to November 23, 1996. (DX 1). These records reveal treatment for similar conditions to the

evidence discussed above. Mr. Eversole was admitted to the hospital on eleven occasions during this time period for complaints of chest pain, shortness of breath, and a smothering feeling. The diagnoses of arteriosclerotic heart disease, COPD, GERD, congestive heart failure, hypertension, and unstable angina appear throughout the hospital records. Reported in these records is that Mr. Eversole suffered a myocardial infarction on April 30, 1995 and also on January 24, 1994. These records reflect treatment by Drs. Elmer B. Ratcliff, Mark Einbecker, Donald Wakefield, Vidya Yalamachi and John P. Loventhal.

In addition, the record contains Appalachian Regional Hospital records from August 16, 1968 to August 21, 1968. (DX 1). Dr. Donald L. Martin treated Claimant for acute coronary insufficiency and a "healed myocardial infarction."

The record also contains hospital records from the St. Joseph Hospital in Lexington, Kentucky. (EX 1). On October 20, 2002, Claimant was transferred to St. Joseph from the Appalachian Regional Hospital with "questionable" congestive heart failure. On October 22, 2002, Dr. Dennis L. Havens implanted a pacemaker.

Claimant was admitted to St. Joseph Hospital on February 14, 2000. A heart catheterization was performed on February 15, 2000. Dr. Bill H. Harris discharged Claimant on February 16, 2000, diagnosing unstable angina, a history of arteriosclerotic heart disease, hypertension, dyslipidemia, hiatal hernia, bronchitis, a history of pneumoconiosis, a history of hyperuricemia and arthritis. Dr. Harris discharged Claimant with "temporary total cardiac disability."

Claimant was admitted to St. Joseph Hospital on January 24, 1994 and discharged on January 30, 1994. A heart catheterization was performed and a temporary pacemaker was implanted on January 24, 1994. An arteriography was performed on January 26, 1994. Drs. Dennis Kelly and Jamie J. Jacobs discharged Claimant diagnosing arteriosclerotic heart disease, hypertension, dyslipidemia, ongoing tobacco abuse and bronchitis.

DISCUSSION AND APPLICABLE LAW

Because Claimant filed his application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. To establish entitlement to

benefits under this part of the regulations, a claimant must prove by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. 20 C.F.R. §725.202(d); *See Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-112 (1989). In *Director, OWCP v. Greenwich Collieries, et al.*, 114 S. Ct. 2251 (1994), the U.S. Supreme Court stated that where the evidence is equally probative, the claimant necessarily fails to satisfy his burden of proving the existence of pneumoconiosis by a preponderance of the evidence.

Modification of a Duplicate Claim

Section 725.310 provides that a claimant may file a petition for modification within one year of the last denial of benefits. Modification petitions may be based upon a change in condition or a mistake in a determination of fact. 20 C.F.R. § 725.310(a) (2000).

In this case, Claimant submitted a timely petition for modification of the denial of his third claim for benefits. Claimant's original claim for benefits was denied by an administrative law judge on March 7, 1975. (DX 1). Claimant's second claim for benefits was denied by the District Director on October 16, 1986. (DX 1). The third claim for benefits was denied on March 12, 1999 by an administrative law judge. When modification of a duplicate claim is sought, an administrative law judge must determine whether the newly submitted evidence, in conjunction with the evidence submitted with the duplicate claim, is sufficient to establish a material change in conditions pursuant to § 725.309. *See Hess v. Director, OWCP*, 21 BLR 1-141, 1-143 (1998); *Sharp v. RAG American Coal Co.*, BRB No. 02-0358 (Jan. 10, 2003) (unpublished); *Crum v. Wolf Creek Collieries*, BRB Nos. 98-1594 BLA and 98-1594 BLA-A (Sept. 28, 1999) (unpublished).

The provisions of Section 725.309(d) apply to duplicate claims and are intended to provide relief from the traditional notions of *res judicata*. Under Section 725.309(d), duplicate claims must be denied on the grounds of the prior denial unless the evidence demonstrates "a material change in condition." 20 C.F.R. § 725.309(d) (2000). The United States Circuit Courts of Appeals have developed divergent standards to determine whether a material change in conditions has occurred. Because Claimant last worked as a coal miner in the state of Kentucky, the law as

interpreted by the Sixth Federal Circuit applies to this claim. *Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989).

Under the Sixth Circuit's approach, an administrative law judge must analyze whether the newly-submitted evidence in a duplicate claim demonstrates a worsening of the claimant's condition to determine whether a material change in condition is established. *Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602, (6th Cir. 2001); *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994); *Steward v. Wampler Brothers Coal Co.*, 22 BLR 1-80 (2000)(en banc); *Flynn v. Grundy Mining Co.*, 21 BLR 1-40 (1997). The administrative law judge must consider all of the new evidence, both favorable and unfavorable, to determine whether it proves at least one of the elements of entitlement that formed the basis for the prior denial. In addition, the administrative law judge must assess whether the newly-submitted evidence is substantially more supportive of the claim or how it differs qualitatively from the earlier evidence. *Kirk*, 264 F.3d at 609; *Ross*, 42 F.3d at 999.

In the denial of Mr. Eversole's prior claim, the administrative law judge determined that the evidence failed to determine that Claimant was totally disabled due to pneumoconiosis. If the newly-submitted evidence establishes a worsening in Claimant's condition, it will demonstrate a material change in condition. Then, I must review the entire record to determine entitlement to benefits and compare the sum of the newly-submitted evidence with the earlier evidence. *See Ross*, 42 F.3d at 999; *Kirk*, 264 F.3d at 609. In addition, if a mistake in determination of fact is discovered, I must review the entire record to determine entitlement to benefits.

I have found that the record supports a finding of 36.5 years of coal mine employment. The previous decision found 24.25 years of qualifying coal mine employment. Therefore, I conclude that the prior decision contains a mistake in determination of fact and I must review the entire record to determine entitlement to benefits.

Pneumoconiosis and Causation

Under the Act, "'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-

ray evidence. In evaluating the x-ray evidence, I assign heightened weight to interpretations of physicians who qualify as either a board-certified radiologist or "B" reader. *See Dixon v. North Camp Coal Co.*, 8 BLR 1-344, 1-345 (1985). I assign greatest weight to interpretations of physicians with both of these qualifications. *See Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993); *Sheckler v. Clinchfield Coal Co.*, 7 BLR 1-128, 1-131 (1984). Because pneumoconiosis is a progressive disease, I also may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *See Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149, 1-154 (1989) (en banc); *Casella v. Kaiser Steel Corp.*, 9 BLR 1-131, 1-135 (1986).

The evidence of record contains fifty-three interpretations of thirty-three chest x-rays. Of these interpretations, seventeen were negative for pneumoconiosis, nineteen were positive and seventeen were not read for pneumoconiosis. Of the negative interpretations, eleven were read by dually qualified physicians, three were read by B-readers and three were read by physicians with neither qualification. Of the positive interpretations nine were read by dually qualified physicians, three by B-readers and seven by physicians with neither qualification. I assign the greatest weight to the most recent x-ray evidence. Since 2001, Claimant submitted to five chest x-rays for the purpose of diagnosing pneumoconiosis. The record contains ten interpretations of those five x-rays. Of those eleven interpretations, seven were positive for pneumoconiosis, while three were negative. Of the seven positive interpretations, four were read by dually qualified physicians, one by a B-reader and two by physicians with neither qualification. Of the four negative interpretations, two were read by dually qualified physicians and one by a B-reader. The most recent chest x-ray was taken on November 25, 2003 and antedates the previous x-ray evidence by at least one year. This x-ray was interpreted by a B-reader and is unchallenged in the record. Because the positive readings constitute the majority of most recent interpretations and are verified by more, highly-qualified physicians, I find that the x-ray evidence supports a finding of pneumoconiosis under Section 718.202(a)(1).

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy evidence. This section is inapplicable to this claim because the record contains no such evidence.

Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Because the record contains no such evidence, this presumption is unavailable. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Because none of the above presumptions apply to this claim, Claimant has not established pneumoconiosis pursuant to Section 718.202(a)(3).

Section 718.202(a)(4) provides that a claimant may establish the presence of pneumoconiosis through a reasoned medical opinion.

Dr. Broudy is the physician to have examined Claimant most recently. His examination antedates the previous examinations by at leas one year. Dr. Broudy diagnosed Claimant with pneumoconiosis based on radiological evidence, examination findings and a review of the medical evidence. I find Dr. Broudy's opinion to be well documented and reasoned and entitled to full weight. As Dr. Broudy is a pulmonary specialist, I assign his opinion additional weight.

Dr. Fino found insufficient evidence in his review of the medical evidence of record to support a diagnosis of pneumoconiosis. He opined that the medical evidence demonstrated a respiratory condition consistent with long-term cigarette smoking. I find Dr. Fino's opinion to be well documented and reasoned and entitled to full weight. As Dr. Fino is a pulmonary specialist, I assign his opinion additional weight.

Dr. Repsher reviewed the medical evidence of record and opined that the record "may" support a diagnosis of pneumoconiosis. Dr. Repsher's opinion states that the radiological evidence supports a diagnosis of pneumoconiosis and is insufficient to support such a diagnosis. I find Dr. Repsher's opinion to be equivocal and inconsistent; therefore, I assign it less weight.

Dr. Dahhan found insufficient evidence to support a diagnosis of pneumoconiosis. He based this determination on a review of the medical evidence of record, examination findings, normal pulmonary function testing, variable arterial blood gas

study results and a lack of radiological evidence. I find Dr. Dahhan's opinion to be well documented and reasoned and entitled to full weight. As Dr. Dahhan is a pulmonary specialist, I assign his opinion additional weight.

Dr. Hussain diagnosed Claimant with pneumoconiosis based on a positive chest x-ray and the results of a pulmonary function study. I find Dr. Hussain's opinion to be well documented and reasoned regarding the diagnosis of pneumoconiosis and assign his opinion full weight. As Dr. Hussain is a pulmonary specialist, I assign his opinion additional weight.

Dr. Baker diagnosed Claimant with pneumoconiosis based on a positive chest x-ray and Claimant's history of coal dust exposure. A diagnosis of pneumoconiosis based on a positive chest x-ray and history of dust exposure alone is not a well documented and reasoned opinion. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000). Dr. Baker provided no other basis for the diagnosis of pneumoconiosis; therefore, I find his opinion to be poorly documented and reasoned on that issue. Dr. Baker also diagnosed Claimant with chronic obstructive airway disease and chronic bronchitis. He did not address the etiology of these conditions. Thus, I also find his opinion to be incomplete regarding these diagnoses.

In their 1997 reports, Drs. Dahhan and Wicker found insufficient evidence to support a diagnosis of pneumoconiosis. Dr. Dahhan opined that the evidence did not support a diagnosis of pneumoconiosis. He also diagnosed Claimant with COPD, but determined that smoking was the sole cause as evidenced by pulmonary function studies and the absence of complicated pneumoconiosis. I find his opinion to be well documented and reasoned. Dr. Wicker stated that he "sees no evidence of pneumoconiosis," but does not discuss the basis of this opinion. An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984). *See also Phillips v. Director, OWCP*, 768 F.2d 982 (8th Cir. 1985); *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Waxman v. Pittsburgh & Midway Coal Co.*, 4 B.L.R. 1-601 (1982). I find Dr. Wicker's opinion to be conclusory and assign it less weight.

Dr. Williams examined Claimant in 1979, 1984 and 1986. In the latter opinion, he diagnosed Claimant with pneumoconiosis based on a positive chest x-ray and examination findings. I

find his opinion to be well-documented and reasoned regarding the diagnosis of pneumoconiosis.

Dr. Nash issued a 1985 medical opinion in which he diagnosed Claimant with pneumoconiosis based on a positive chest x-ray, objective testing and examination findings. I find his opinion to be well documented and reasoned regarding the diagnosis of pneumoconiosis.

Dr. Boggs diagnosed Claimant with pneumoconiosis in his 1985 medical opinion. Dr. Boggs did not provide his basis or reasoning for the diagnosis. Therefore, I find his opinion to be poorly documented and reasoned and entitled to less weight.

Dr. Jones diagnosed Claimant with pneumoconiosis in a 1973 medical opinion. He based his diagnosis on a positive chest x-ray. As Dr. Jones provided no other basis for his opinion, I assign his opinion less weight. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000).

The record contains numerous hospital and treatment records describing Claimant's medical treatment over a period of thirty-six years. These records reflect treatment for Claimant's cardiac condition and respiratory condition. These records are supportive of those physicians discussed above who diagnosed Claimant with COPD and cardiac conditions. However, these records do not address the etiology of Claimant's COPD. In addition, the records do not reveal a diagnosis of clinical pneumoconiosis. Therefore, I find these records to be supportive of the narrative medical evidence of record, but insufficient to support a diagnosis of pneumoconiosis.

In sum, I place the greatest weight on Dr. Broudy's November 25, 2003 opinion. Dr. Broudy issued a well documented and reasoned opinion, which relied on findings from a physical examination and a review of the medical evidence of record. Dr. Broudy is the physician of record to have most recently examined Claimant. For these reasons, I find Dr. Broudy's opinion to contain the most complete and current assessment of Claimant's condition. I conclude that Dr. Broudy's opinion supported by those of Drs. Hussain, Baker, Nash, Boggs, Williams and Jones outweigh the opinions of Drs. Fino, Repsher, Dahhan, and Wicker. Consequently, Claimant has established pneumoconiosis under Section 718.202(a)(4).

Causation of Pneumoconiosis

Once pneumoconiosis has been established, the burden is upon the Claimant to demonstrate by a preponderance of the evidence that the pneumoconiosis arose out of the miner's coal mine employment. Section 718.203(b) provides:

> If a miner who is suffering or has suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment.

I have found that Claimant was a coal miner for 36.5 years, and that he has pneumoconiosis. Claimant is entitled to the presumption that his pneumoconiosis arose out of his employment in the coal mines. No physician opining as to the presence of pneumoconiosis offers an alternative cause to rebut this presumption. *See Smith v. Director, OWCP,* 12 BLR 1-156 (1989). Therefore, I find that Claimant's pneumoconiosis arose from his coal mine employment.

Total Disability

A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204(b). Non-respiratory and non-pulmonary impairments have no bearing on a finding of total disability. *See Beatty v. Danri Corp.*, 16 BLR 1-11, 1-15 (1991). Section 718.204(b) provides several criteria for establishing total disability. Under this section, I first must evaluate the evidence under each subsection and then weigh all of the probative evidence together, both like and unlike, to determine whether Claimant has established total respiratory disability. *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195, 1-198 (1987).

Under Sections 718.204(b)(2)(i) and (ii), total disability may be established with qualifying pulmonary function studies or arterial blood gas studies. A "qualifying" pulmonary function study or arterial blood gas study yields values that are equal to or less than the applicable table values found in Appendices B and C of Part 718. *See* 20 C.F.R. § 718.204(b)(2)(i), (ii). A "non-qualifying" test produces results that exceed the table values.

The record contains three qualifying pulmonary function studies. Dr. Hussain's study of June 6, 2001 meets the qualifying criteria. This pulmonary function study was reviewed by Dr. N.K. Burki, who found it invalid as the curve shapes demonstrated suboptimal effort. In addition, Dr. Hussain recorded that Claimant's cooperation with the test was fair rather than good. For these reasons, I find the June 6, 2001 pulmonary function study to be invalid. The September 2, 1997 pulmonary function study administered by Dr. Dahhan is qualifying. Dr. Dahhan stated in his narrative report that this study was invalid due to suboptimal effort. I credit Dr. Dahhan's opinion and find the September 2, 1997 pulmonary function study invalid. The August 16, 1985 study is the final qualifying pulmonary function study. Dr. Nash reported the test to be valid and it is unchallenged in the record. The remaining ten pulmonary function studies are non-qualifying. I place considerable weight on the most recent pulmonary function study, administered on November 25, 2003. This study is non-qualifying. In addition, the three valid pulmonary function studies administered in 2001 are non-qualifying. I find that these four most recent non-qualifying studies, supported by the prior seven non-qualifying studies, outweigh the August 16, 1985 qualifying study. Consequently, I conclude that the evidence is insufficient to support a finding of total disability under Section 718.204(b)(2)(i).

The record contains the results of twelve arterial blood gas studies. Three of these studies are qualifying. I place the greatest weight on the most recent arterial blood gas study, administered on November 25, 2003. This is a qualifying study. The remaining qualifying studies were administered on June 6, 2001 and August 16, 1986. The most recent study antedates the remaining studies by at least two years. I find that this study, supported by the two other qualifying studies, outweighs the non-qualifying studies of record. As a result, I find that Claimant has established total disability under Section 718.204(b)(2)(ii).

Section 718.204(b)(2)(iii) provides that a claimant may prove total disability through evidence establishing cor pulmonale with right-sided congestive heart failure. The hospital records report that Claimant suffers from recurrent congestive heart failure. However, the records do not demonstrate that Claimant suffered from cor pulmonale with right-sided congestive heart failure. I find the hospital

records insufficient to support a finding of total disability under Section 718.204(b)(2)(iii).

Under Section 718.204(b)(2)(iv), total disability may be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a respiratory or pulmonary impairment prevents the miner from engaging in his usual coal mine work or comparable and gainful work.

Dr. Broudy opined that Claimant is totally disabled due to his cardiac condition and COPD. He based this information on the results of the pulmonary function study, arterial blood gas study, examination findings and a review of the medical evidence of record. I find Dr. Broudy's opinion to be well documented and reasoned and entitled to full weight. As Dr. Broudy is a pulmonary specialist, I assign his opinion additional weight.

Dr. Fino opined that Claimant has the respiratory capacity to engage in coal mine employment, but is totally disabled due to his cardiac condition. Dr. Fino explained that the poor values achieved in the pulmonary function and arterial blood gas studies were caused by Claimant's cardiac condition. I find Dr. Fino's opinion to be well documented and reasoned and entitled to full weight. As Dr. Fino is a pulmonary specialist, I assign his opinion additional weight.

Dr. Repsher opined that Claimant does not have a totally disabling respiratory impairment. He opined that the pulmonary function studies of record demonstrate a mild impairment and that the hypoxemia, shown by the arterial blood gas studies, is due to Claimant's heart condition. I find Dr. Repsher's opinion to be well documented and reasoned and entitled to full weight. As Dr. Repsher is a pulmonary specialist, I assign his opinion additional weight.

Dr. Dahhan opined that Claimant retains the respiratory capacity to engage in coal mine employment. He based this determination on normal pulmonary function studies, examination findings and the medical evidence of record. He explained that Claimant's hypoxemia is caused by his cardiac condition. I find Dr. Dahhan's opinion to be well documented and reasoned and entitled to full weight. As Dr. Dahhan is a pulmonary specialist, I assign his opinion additional weight.

Dr. Hussain opined that Claimant has a severe respiratory impairment which prevents him from engaging in coal mine work.

He based this determination on examination findings and the results of the pulmonary function and arterial blood gas studies. As discussed above, I find the June 6, 2001 pulmonary function study to be invalid. As Dr. Hussain's opinion is based, in part, on the results of this pulmonary function study, I find his opinion to be poorly documented and reasoned regarding the issue of total disability.

Dr. Baker opined that Claimant has a 10 to 25% impairment and should avoid further coal dust exposure. A recommendation against further exposure to coal dust is not a finding that a miner cannot do the work, and not a finding of total disability. *Zimmerman v. Director, OWCP*, 871 F.2d 564, 567, 12 BLR 2-254 (6th Cir. 1989). Dr. Baker does not address the basis for his opinion and does not address Claimant's ability to engage in comparable employment. For these reasons, I find Dr. Baker's opinion to be poorly documented and reasoned and entitled to less weight.

Dr. Wicker opined that Claimant has the respiratory capacity to engage in coal mine employment. His opinion contains no information regarding Claimant's former coal mine work or the exertional requirements thereof. Therefore, I find his opinion to be conclusory and entitled to less weight.

In Dr. Dahhan's September 3, 1997 medical opinion, he opined that Claimant has the respiratory capacity for coal mine work. He based this determination on examination findings and objective testing. I find his opinion to be well documented and reasoned.

Dr. Broudy opined in his September 12, 1986 medical report that Claimant did not have a totally disabling respiratory impairment, based on normal pulmonary function study results and a lack of radiological evidence. I find his opinion to be well documented and reasoned.

Dr. Nash opined that Claimant has a totally disabling respiratory impairment, based on pulmonary function study results. I find his opinion to be well documented and reasoned.

Dr. Boggs stated that Claimant was totally disabled for coal mine employment. He did not provide the basis or reasoning for this opinion. I find his opinion to be poorly documented and reasoned.

Drs. Jones and Williams made no determination of Claimant's ability to engage in coal mine employment.

The treatment records contain no assessment of Claimant's ability to engage in coal mine employment; therefore, I do not find them probative on the issue of total disability.

The hospital records do not address Claimant's ability to perform coal mine work; however, recommendations of limited activity are made. Claimant was discharged from the hospital on June 24, 2000 with the recommendation that Claimant restrict overall activity. It is unclear from the discharge summary whether the restriction is due to Claimant's pulmonary or cardiac condition. On February 14, 2000, Claimant was discharged from the hospital with "temporary total cardiac disability." Non-respiratory and non-pulmonary impairments have no bearing on a finding of total disability. *See Beatty v. Danri Corp.*, 16 BLR 1-11, 1-15 (1991). The hospital records do not contain an assessment of Claimant's respiratory or pulmonary capacity for coal mine employment; therefore, I find them to be non-probative on the issue of total disability.

I assign the greatest weight to the November 25, 2003 opinion of Dr. Broudy. He most recently examined the Claimant and issued a well documented and reasoned opinion. Dr. Broudy opined that Claimant was totally disabled due to COPD and his cardiac condition. Although Drs. Fino and Repsher submitted recent consultative medical reports, those reports were based on data collected from 2001 and before. Dr. Broudy had the advantage of a recent examination and a review of the medical evidence of record. I find that Dr. Broudy was able to analyze Claimant's condition more completely than other physicians of record. In addition, his opinion is supported by the lesser-weighted opinions of Drs. Baker and Hussain, as well as the earlier-submitted opinions of Drs. Nash and Boggs. I conclude that the medical evidence supports a finding of total disability under Section 718.204(b)(2)(iv).

In sum, the record contains one valid qualifying pulmonary function study, two invalid qualifying pulmonary function studies, eleven non-qualifying pulmonary function studies, three qualifying arterial blood gas studies, nine non-qualifying arterial blood gas studies, and physician opinions that, in total, support a finding of total disability. I have found both the arterial blood gas studies and physician opinions sufficient to support a finding of total disability. I conclude that the

evidence supports a finding of total disability under Section 718.204(b)(2).

Total Disability Due to Pneumoconiosis

Upon demonstrating that he is totally disabled, Claimant must establish that his total disability is due at least in part to pneumoconiosis. *Peabody Coal Co. v. Hill*, 123 F.3d 412, 21 BLR 2-192 (6th Cir. 1997); *Youghiogheny & Ohio Coal Co. v. McAngues*, 996 F.2d 130, 17 BLR 2-146 (6th Cir. 1993), *cert. denied*, 114 S.Ct. 683 (1994); *Adams v. Director, OWCP*, 886 F.2d 818, 13 BLR 2-52 (6th Cir. 1989). 20 C.F.R. §718.204(c)(1) provides that a miner is totally disabled due to pneumoconiosis where pneumoconiosis, as defined in §718.201, is a substantially contributing cause of the miner's total disability. The Sixth Circuit holds that total disability must be due at least in part to pneumoconiosis. *Adams v. Director, OWCP*, 886 F.2d 818, 825 (6th Cir. 1989); *Zimmerman v. Director, OWCP*, 871 F.2d 564, 566 (6th Cir. 1989).

The reasoned medical opinions of those physicians who diagnosed the existence of pneumoconiosis and that the miner was totally disabled are more reliable for assessing the etiology of the miner's total disability. *See, e.g. Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819 (4th Cir. 1995); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995).

Of the newly-submitted evidence, Drs. Baker, Dahhan, Repsher, and Fino opined that Claimant does not have a totally disabling respiratory impairment.

Dr. Broudy determined that Claimant is totally disabled due to COPD and his cardiac condition. Dr. Broudy opined that Claimant's COPD is due solely to smoking, but does not discuss how he arrived at this determination. I find Dr. Broudy's opinion to be conclusory on the issue of total disability causation and entitled to less weight.

Dr. Hussain opined that Claimant has a totally disabling respiratory impairment due to pneumoconiosis. As the basis for his determination of total disability, Dr. Hussain noted severe dyspnea, effort intolerance and hypoxemia. He opined that pneumoconiosis is responsible for 80% of Claimant's respiratory impairment. He did not explain the rationale behind this assessment or state the cause of the remaining 20% of the impairment. I find Dr. Hussain's opinion to be conclusory and entitled to less weight.

The newly-submitted evidence also contains hospital and treatment records. The treatment records from Dr. Ratcliff are largely illegible and no determination of a totally disabling respiratory impairment or its cause can be identified. Dr. Yalamachi's treatment records reflect an assessment of Claimant's cardiac condition. I do not find the treatment records probative on the issue of total disability causation. The hospital records from St. Joseph Hospital and the Appalachian Regional Hospital are also inconclusive on the issue of total disability causation. The records report for a June 24, 2000 discharge that Claimant should restrict overall activity; however, it is unclear whether Claimant's respiratory or cardiac condition required this restriction. On February 16, 2000, Claimant was discharged from St. Joseph with temporary total cardiac disability. Other than these two reports, the hospital records do not address Claimant's respiratory capacity for coal mine employment. Furthermore, the records do not address respiratory impairment or the possible cause or causes thereof. For these reasons, I find the hospital records to be non-probative on the issue of total disability causation.

Of the earlier-submitted evidence, Drs. Eli C. Boggs, Arthur J. Nash and Abdul K. Dahhan opined that Claimant had a totally disabling respiratory impairment. Dr. Boggs did not discuss whether pneumoconiosis was a significantly contributing factor in Claimant's respiratory impairment. He diagnosed Claimant with COPD, pneumoconiosis, asthmatic bronchitis and bronchiolitis; however, he did not determine to what extent these conditions contributed to the respiratory impairment. In addition, Dr. Boggs did not discuss the cause or causes of Claimant's COPD. Dr. Nash determined that Claimant suffered a 40% loss of lung function and that this condition "is a direct cause and/or aggravated by his employment as an underground Federal Coal Mine Inspector." (DX 1). He provided no basis for this opinion. Dr. Dahhan opined that Claimant's disabling respiratory impairment was due solely to smoking. He based this conclusion on the results of the pulmonary function study from the September 2, 1997 physical examination indicating an obstructive ventilatory defect. He explained that the radiological evidence was insufficient to support a finding of complicated pneumoconiosis that would result in airway obstruction.

Drs. Jones, Travis, and Williams made no determination of total disability. Dr. Wicker determined that Claimant did not have a totally disabling respiratory impairment. Dr. Broudy

opined in his September 12, 1986 report that Claimant did not have a respiratory impairment.

Drs. Broudy and Hussain are the only physicians among the newly-submitted evidence who determined that Claimant has a totally disabling respiratory impairment. I have found both their opinions to be poorly reasoned regarding the issue of total disability causation. Therefore, Claimant has failed to demonstrate, by a preponderance of the evidence that his totally disabling respiratory impairment is due to pneumoconiosis.

Claimant has established pneumoconiosis arising out of coal mine employment and that he has a totally disabling respiratory impairment. However, Claimant has failed to establish that his totally disabling respiratory impairment is due to pneumoconiosis. Accordingly, this claim must be denied.

Attorney's Fee

The award of an attorney's fee is permitted only in cases in which the Claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the claim.

ORDER

The claim of Jesse J. Eversole for benefits under the Act is hereby **DENIED**.

A

Rudolf L. Jansen
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington D.C. 20013-7601. A copy of this Notice of Appeal also must be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.